FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0008201

Facility Name: Du Page Convalescent Center

Address: 400 North County Farm Road (Number) Wheaton, Illinois (City) 60187 (Zip Code)

County: Du Page

Telephone Number: (630) 665-6400 **Fax #** (630) 665-2446

IDPA ID Number: 36-6006551-002

Date of Initial License for Current Owners: Prior to 1935

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Patrick Szajkovics **Telephone Number:** (847) 259-7373, Ext. 111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from Dec. 1, 1999 to Nov. 30, 2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) James A. Freund

(Title) Financial Services Manager

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Patrick Szajkovics, Consultant

(Firm Name & Address) Strategic Reimbursement, Inc.
3315 W. Algonquin Rd, S.110 Rolling Meadows, IL 60008

(Telephone) (847) 259-7373 **Fax #** (847) 259-9869

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone #** (217) 782-1630

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	508	Skilled (SNF)	508	185,928	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	508	TOTALS	508	185,928	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	129,871	31,765	9,615	171,251	8
9	SNF/PED					9
10	ICF	2,398	377	0	2,775	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	132,269	32,142	9,615	174,026	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.60%

D. How many bed-hold days during this year were paid by Public Aid? 1,618 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels, Employee meals, Empl. Pharmacy, Empl. Therapy, County Laundry

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started Pre - 1935

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 6,540

Medicare Intermediary Mutual Of Omaha Insurance Company

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/2000 Fiscal Year: 11/30/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	1,170,958	334,672	26,530	1,532,160		1,532,160	(133,966)	1,398,194			1
2	Food Purchase		964,846		964,846		964,846	(132,300)	832,546			2
3	Housekeeping	916,408	129,791	73,846	1,120,045		1,120,045		1,120,045			3
4	Laundry	264,687	127,186	259,239	651,112		651,112	(2,122)	648,990			4
5	Heat and Other Utilities			1,480,168	1,480,168		1,480,168		1,480,168			5
6	Maintenance		1,162	875,268	876,430		876,430	(7,147)	869,283			6
7	Other (specify):*											7
8	**TOTAL General Services**	2,352,053	1,557,657	2,715,051	6,624,761		6,624,761	(275,535)	6,349,226			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	11,603,728	855,777	332,614	12,792,119	(868,746)	11,923,373		11,923,373			10
10a	Therapy	512,396	26,621	432,506	971,523		971,523		971,523			10a
11	Activities	562,454	30,342	1,599	594,395		594,395		594,395			11
12	Social Services	315,873	2,768	1,965	320,606		320,606		320,606			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	12,994,451	915,508	768,684	14,678,643	(868,746)	13,809,897		13,809,897			16
	C. General Administration											
17	Administrative	273,054		906,683	1,179,737		1,179,737	24,377	1,204,114			17
18	Directors Fees											18
19	Professional Services			174,841	174,841		174,841		174,841			19
20	Dues, Fees, Subscriptions & Promotions			40,105	40,105		40,105		40,105			20
21	Clerical & General Office Expenses	902,049	125,324	263,218	1,290,591		1,290,591	(12,158)	1,278,433			21
22	Employee Benefits & Payroll Taxes			4,221,252	4,221,252		4,221,252		4,221,252			22
23	Inservice Training & Education											23
24	Travel and Seminar			58,065	58,065		58,065	(4,724)	53,341			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			278,538	278,538		278,538		278,538			26
27	Other (specify):* Bad Debt Exp			135,281	135,281		135,281	(135,281)				27
28	**TOTAL General Administration**	1,175,103	125,324	6,077,983	7,378,410		7,378,410	(127,786)	7,250,624			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	16,521,607	2,598,489	9,561,718	28,681,814	(868,746)	27,813,068	(403,321)	27,409,747			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Du Page Convalescent Center #0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,269,282	1,269,282		1,269,282	361	1,269,643			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,269,282	1,269,282		1,269,282	361	1,269,643			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	316,320	1,231,617	24,329	1,572,266	868,746	2,441,012	(28,751)	2,412,261			39
40	Barber and Beauty Shops	110,630		5,003	115,633		115,633		115,633			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							278,892	278,892			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	426,950	1,231,617	29,332	1,687,899	868,746	2,556,645	250,141	2,806,786			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	16,948,557	3,830,106	10,860,332	31,638,995		31,638,995	(152,819)	31,486,176			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,147)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(2,122)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(1,624)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,724)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(135,281)	27		24
25	Fund Raising, Advertising and Promotional	(15,105)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	13,184			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (152,819)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (152,819)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program	X		868,746	10	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 868,746		47

STATE OF ILLINOIS

Du Page Convalescent Center

ID# 0008201

Report Period Beginning: Dec. 1, 1999

Ending: Nov. 30, 2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Employee Reimbursements - Other Ancillary	$ (28,751)	39	1
2	Cafeteria Income - Food	(91,578)	2	2
3	Cafeteria Income - Other Costs	(92,732)	1	3
4	Catering Income - Food	(38,588)	2	4
5	Catering Income - Other Costs	(39,074)	1	5
6	Meals On Wheels - Food	(2,134)	2	6
7	Meals On Wheels - Other Costs	(2,160)	1	7
8	Provider Participation Fee	278,892	42	8
9	County Board Cost Allocation	24,377	17	9
10	FY 1989 IDPA Audit Aje for Assets	361	30	10
11	Other Misc Revenues	4,571	21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	13,184		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(133,966)	0	0	0	0	0	0	0	0	0	0	(133,966)	1
2	Food Purchase	(132,300)	0	0	0	0	0	0	0	0	0	0	(132,300)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(2,122)	0	0	0	0	0	0	0	0	0	0	(2,122)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(7,147)	0	0	0	0	0	0	0	0	0	0	(7,147)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(275,535)	0	0	0	0	0	0	0	0	0	0	(275,535)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	24,377	0	0	0	0	0	0	0	0	0	0	24,377	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(12,158)	0	0	0	0	0	0	0	0	0	0	(12,158)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,724)	0	0	0	0	0	0	0	0	0	0	(4,724)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(135,281)	0	0	0	0	0	0	0	0	0	0	(135,281)	27
28	**TOTAL General Administration**	(127,786)	0	0	0	0	0	0	0	0	0	0	(127,786)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(403,321)	0	0	0	0	0	0	0	0	0	0	(403,321)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Du Page Convalescent Center # 0008201 **Report Period Beginning:** Dec. 1, 1999 **Ending:** Nov. 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	361	0	0	0	0	0	0	0	0	0	0	361	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	361	0	0	0	0	0	0	0	0	0	0	361	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(28,751)	0	0	0	0	0	0	0	0	0	0	(28,751)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	278,892	0	0	0	0	0	0	0	0	0	0	278,892	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	250,141	0	0	0	0	0	0	0	0	0	0	250,141	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(152,819)	0	0	0	0	0	0	0	0	0	0	(152,819)	45

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: v. 30, 2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Du Page County Government
Street Address: 421 N. County Farm Road (Finance Dept.)
City / State / Zip Code: Wheaton, Illinois 60187
Phone Number: (630) 682-7449
Fax Number: (630) 682-7964

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	I.M.R.F. & Social Security	Direct Cost	9,369,418	48	$ 9,369,418	$ 0	2,368,383	$ 2,368,383	1
2	21	Furniture & Equip. -Small Value	Direct Cost	31,258	48	31,258	0	18,058	18,058	2
3	19	Technical & Prof. Services	Direct Cost	405,993	48	405,993	0	8,250	8,250	3
4	22	Statutory & Fiscal Charges	Direct Cost	6,709,868	48	6,709,868	0	562,273	562,273	4
5	19	Finance & Auditor allocation	# of A/P Claims	564,416	148	564,416	252,349	96,793	96,793	5
6	19	County Audit	% of Time Spent	168,050	11	168,050	0	6,722	6,722	6
7	19	General Acctg & Budgeting	% of all Depts.	788,896	48	788,896	365,909	16,435	16,435	7
8	21	Mail Delivery	Wtd. Avg. # of Del.	250,000	43	250,000	180,862	5,769	5,769	8
9	22	Workers Comp. Claims	Direct Cost	702,703	48	702,703	0	136,154	136,154	9
10	22	Workers Comp. Premiums	# of Claims	435,040	48	435,040	0	95,789	95,789	10
11	26	Property Insurance	Building Value	92,271	43	92,271	0	8,259	8,259	11
12	26	Gen/Prof Liab. Ins. & Surety Bnd	Direct Cost	4,634,017	48	4,634,017	0	245,515	245,515	12
13	22	Unemploymnt Comp Prem & Exp	Direct Cost & FTE	125,017	48	125,017	0	38,699	38,699	13
14	26	Service Retention Fee	# of Ins Claims	79,599	19	79,599	0	24,764	24,764	14
15	17	Maintenance of Grounds	Square Footage	573,505	51	573,505	308,041	92,207	92,207	15
16	5	Space & HVAC allocation	Square Footage	6,501,825	48	6,501,825	1,775,960	1,154,836	1,154,836	16
17	17	Security	Square Footage	940,524	50	940,524	554,676	224,615	224,615	17
18	6	Building Maintenance	Direct Cost	2,718,830	35	2,718,830	742,643	871,154	871,154	18
19	6	Repair & Maint of equipment	Direct Cost	103,518	43	103,518	0	4,114	4,114	19
20	17	Personnel Costs	Direct Cost & FTE	2,038,344	45	2,038,344	1,104,663	552,130	552,130	20
21	17	Purchasing	# of Purchase Orders	584,584	53	584,584	313,132	25,732	25,732	21
22	17	County Administrator	Dept Size	225,000	24	225,000	225,000	12,000	12,000	22
23	17	County Board Allocation	Committee Assignmnts	1,133,495	50	1,133,495	1,133,495	24,377	24,377	23
24										24
25	TOTALS					$ 39,176,171	$ 6,956,730		$ 6,593,028	25

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Du Page Convalescent Center # 0008201 **Report Period Beginning:** Dec. 1, 1999 **Ending:** Nov. 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 257,371 B. General Construction Type: Exterior Masonry Rf. Concrete Frame Steel Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility Buildings	400,000	Various	$ 784,360	1
2					2
3	TOTALS	400,000		$ 784,360	3

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	288		1947	1947	$ 70,858	$	30	$	$	$ 70,858	4
5				1964	1,172,064	34,473	34	34,473		606,142	5
6	104			1978	4,456,548	148,551	30	148,551		3,354,790	6
7	16			1979	1,750,524	58,351	30	58,351		1,235,093	7
8	100			1993	6,516,821	259,038	Various	259,038		1,847,429	8
	Improvement Type**										
9	Mech. Room renovation & heat exchangers			1976	44,372		20			44,372	9
10	Alarm Equip doors & other, Project 181			1977	8,545		20			8,545	10
11	Cyclone Dust Collector			1978	12,188		20			12,188	11
12	Flagpole			1979	844		20			844	12
13	Kitchen Floor replace / ground north remodeling			1981	212,304	10,615	20	10,615		205,358	13
14	South Bldg. Renovation - Phase III			1983	4,134,469	206,724	20	206,724		3,634,889	14
15	Laundry, 3 - Center & nurse station remodeling			1985	261,742	14,134	15/20	14,134		212,004	15
16	Tubs & Parking lot projects & misc.			1989	199,883	9,994	20	9,994		109,105	16
17	Oxygen Manifold - North Building			1990	5,423	271	20	271		2,689	17
18	Ground North & Hydrotherapy remodeling			1991	331,512	18,438	15/20/25	18,438		164,408	18
19	Window Replacement, 3- Center & nurse station remodeling			1992	604,207	33,376	10/15/20/25	33,376		285,086	19
20	Laundry water heaters replace, asphalt rep. & landscaping			1993	588,826	34,963	10/12/15/20	34,963		244,764	20
21	ADA & Elevator upgrades, nurse station remodel & misc.			1994	105,577	6,790	5/10/15/20	6,790		45,504	21
22	Sewage Ejector Pumps replcmnt & carpet replacemnt			1995	31,457	3,146	5/10	3,146		19,658	22
23	Carpeting replace, recreation & volunteer areas & misc.			1996	7,963	1,593	5	1,593		7,555	23
24	Chilled Water Bridges, Liquid Oxygen, Lights refit & elevator			1997	320,587	19,102	5/10/20	19,102		64,188	24
25	Install elevator pit ladders & automatic entrance doors (2)			1998	10,922	950	10/20	950		2,153	25
26	Lobby remodel, carpet, elev, safety system & HVAC upgrade			1999	701,043	76,792	5/10/20	76,792		77,488	26
27	Tubs, Reception, Laundry, Kitchen, Elev, HVAC & Access Rehab			2000	848,131	16,794	5/10/15/20	16,794		16,794	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 22,396,810	$ 954,095		$ 954,095	$	$ 12,271,904	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 2,668,534	$ 257,762	$ 258,123	$ 361	5/10/12/15	$ 1,236,292	37
38	Current Year Purchases	102,137	14,325	14,325		5/10/12/15	14,325	38
39	Fully Depreciated Assets	1,197,227					1,197,227	39
40								40
41	TOTALS	$ 3,967,898	$ 272,087	$ 272,448	$ 361		$ 2,447,844	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43	Snowplowing & Maint.	Various	Various	253,925	37,771	37,771		3/4/10	224,923	43
44	Grounds Maintenance	John Deere Tractor	11/99	12,685	1,269	1,269		10	2,220	44
45	Maintenance & Transport	Ford A-10 Van 2000	11/00	38,971	4,060	4,060		4	4,060	45
46	TOTALS			$ 305,581	$ 43,100	$ 43,100	$		$ 231,203	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	27,454,649	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	1,269,282	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	1,269,643	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	361	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	14,950,951	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning N/A
Ending N/A

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a, Col 8	2097 hrs	69,516				2,097	69,516	4
5	Physician Care	Ln 10, Col 8	visits		3,666	24,000		3,666	24,000	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 8	56185 # of prescrpts	316,320			1,195,940	56,185	1,512,260	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	Ln 39, Col 8		675,470			193,276		868,746	12
13	Other (specify):									13
14	TOTAL			$ 1,061,306	3,666	$ 24,000	$ 1,389,216	61,948	$ 2,474,522	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of Nov. 30, 2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 120,844	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 500,000)	4,931,164		3
4	Supply Inventory (priced at Cost)	306,020		4
5	Short-Term Investments	3,590,000		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	100,785		7
8	Accounts Receivable (owners or related parties)	2,218		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,051,031	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	784,360		13
14	Buildings, at Historical Cost	22,395,209		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,245,588		16
17	Accumulated Depreciation (book methods)	(14,921,463)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	197,001		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 12,700,695	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 21,751,726	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 833,432	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,363,998		30
31	Accrued Taxes Payable (excluding real estate taxes)	109,768		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,307,198	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Accrued Vacation & Sick Pay	81,103		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 81,103	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,388,301	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 18,363,425	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 21,751,726	$	48

***(See instructions.)**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 25,352,459	1
2	Discounts and Allowances for all Levels	(4,047,535)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 21,304,924	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,259,687	6
7	Oxygen	289,136	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,548,823	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,162	13
14	Non-Patient Meals	264,785	14
15	Telephone, Television and Radio	7,147	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,929,423	17
18	Sale of Supplies to Non-Patients	(4,571)	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	28,751	21
22	Laundry	2,122	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,228,819	23
	D. Non-Operating Revenue		
24	Contributions	1,624	24
25	Interest and Other Investment Income***	167,514	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 169,138	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 26,251,704	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	6,624,761	31
32	Health Care	14,678,643	32
33	General Administration	7,378,410	33
	B. Capital Expense		
34	Ownership	1,269,282	34
	C. Ancillary Expense		
35	Special Cost Centers	1,687,899	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 31,638,995	40
41	**Income before Income Taxes (line 30 minus line 40)****	(5,387,291)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (5,387,291)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** N/A **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 16,654,548	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 16,654,548	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,387,291)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Reconciling Item**	879	15
16	Other (describe) **Rounding**	3	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (5,386,409)	17
	B. Transfers (Itemize):		
18	**Contributed Capital**	7,049,124	18
19	**Donated Capital**	46,162	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 7,095,286	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 18,363,425	24 *

*** This must agree with page 17, line 47.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,213	$ 95,244	$ 43.04	1
2	Assistant Director of Nursing	3,176	3,630	144,036	39.68	2
3	Registered Nurses	149,680	168,852	4,132,256	24.47	3
4	Licensed Practical Nurses	25,546	28,057	505,278	18.01	4
5	Nurse Aides & Orderlies	462,828	514,414	6,257,223	12.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	17,307	19,266	438,930	22.78	7
8	Rehab/Therapy Aides	21,289	24,558	343,609	13.99	8
9	Activity Director	1,903	2,199	65,100	29.60	9
10	Activity Assistants	32,507	36,899	497,354	13.48	10
11	Social Service Workers	17,127	19,453	315,874	16.24	11
12	Dietician	6,928	7,695	124,224	16.14	12
13	Food Service Supervisor	5,915	6,272	123,265	19.65	13
14	Head Cook	1,504	1,589	22,573	14.21	14
15	Cook Helpers/Assistants	41,134	44,377	476,083	10.73	15
16	Dishwashers	47,917	50,259	424,813	8.45	16
17	Maintenance Workers					17
18	Housekeepers	81,370	88,623	916,408	10.34	18
19	Laundry	20,029	21,699	264,687	12.20	19
20	Administrator	2,530	2,795	235,189	84.15	20
21	Assistant Administrator	823	911	37,865	41.56	21
22	Other Administrative	8,909	10,268	245,449	23.90	22
23	Office Manager					23
24	Clerical	42,234	46,867	656,600	14.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,381	1,580	46,177	29.23	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,406	5,993	75,487	12.60	31
32	Other Health C: Ns secrt/clrks	24,560	28,600	394,203	13.78	32
33	Other(specify) Barber/Beautcn	6,889	7,914	110,630	13.98	33
34	TOTAL (lines 1 - 33)	1,030,836	1,144,983	$ 16,948,557 *	$ 14.80	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	726	$ 22,017	Ln 1, C 3	35
36	Medical Director				36
37	Medical Records Consultant	257	7,713	Ln 10, C 3	37
38	Nurse Consultant	225	9,000	Ln 10, C 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	16,522	225,294	Ln 10a, C 3	40
41	Occupational Therapy Consultant	9,551	130,634	Ln 10a, C 3	41
42	Respiratory Therapy Consultant	7	255	Ln 10a, C 3	42
43	Speech Therapy Consultant	3,482	52,550	Ln 10a, C 3	43
44	Activity Consultant	16	896	Ln 11, C3	44
45	Social Service Consultant	36	1,890	Ln 12, C 3	45
46	Other(specify) Medicare Consult	240	8,504	Ln 19, C 3	46
47	Medicare PPS Consulting	217	26,083	Ln 19, C 3	47
48	Housekpng Computer Consulting	118	8,850	Ln 3, C 3	48
49	TOTAL (lines 35 - 48)	31,397	$ 493,686		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	580	$ 22,564	Ln 10, C 3	50
51	Licensed Practical Nurses	42	1,199	Ln 10, C 3	51
52	Nurse Aides	3,193	60,265	Ln 10, C 3	52
53	TOTAL (lines 50 - 52)	3,815	$ 84,028		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ron R. Reinecke	Administrator	NONE	$ 152,028
Maureen T, Mc Hugh	Administrator	NONE	83,161
Maureen T, Mc Hugh	Asst. Administr	NONE	15,940
Elizabeth McGowan Welch	Asst. Administr	NONE	21,925
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 273,054

B. Administrative - Other

Description	Amount
Other Contractual expenses	$ 906,683
TOTAL (agree to Schedule V, line 17, col. 3)	$ 906,683
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
County Acctg & Auditor	Acctg & Audit	$ 128,201
Monahan & Cohen	Legal Srvcs	11,587
Strategic Reimb. Svcs, Inc.	Cost Report svcs	35,053
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 174,841

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 231,943
Unemployment Compensation Insurance	38,699
FICA Taxes	1,251,603
Employee Health Insurance	1,085,273
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	1,116,780
Accrued Comp Expense	493,781
Empl Srvc Awards	3,173
TOTAL (agree to Schedule V, line 22, col.8)	$ 4,221,252

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
0		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 82)	574
Life Services Network of Illinois	18,881
NAGNA	4,896
County Nrsg. Home Assn of Illinois	4,080
Health Care Financial Admin	3,648
Managed Health Care Assoc.	3,000
Various Other small amounts	5,026
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,105

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Various	4,724
In-State Travel	
Various	7,191
Seminar Expense	
Various	46,150
Entertainment Expense	(4,724)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 53,341

**See instructions.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 1999 Ending: Nov. 30, 2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **County Nrsg Home Assoc $4080**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **259,921** Line **10, Col 2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **278,892**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **261,972**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **WOLF & COMPANY, CPA'S** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **FINAL NOT YET AVAILABLE**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.